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ABSTRACT

The usefulness and costs of California state/local interagency agreements made to comply with P.L. 94-142, the Education for All Handicapped Children Act, were examined. Ninety-three personal and telephone interviews were conducted in 10 areas: 5 Master Plan Special Education Service Regions (SERS) and 5 "in transition" areas (Departments of Mental Health, Health Services, Developmental Services, and Rehabilitation). Questions asked of staff members touched on such topics as the type of relationship with the other agency, effects on services to students, and needed changes. Despite a lack of summary statistics, major conclusions were drawn from interview responses, including that most respondents reported they had not observed any local impact resulting from the state interagency agreements; most areas had not completed local agreements, which were seen as having limited benefits; most reported that funding levels made more of a difference in services than local agreements did; a major benefit of agreements was the process of its development rather than its content, due to the aid in understanding each agency's capacities and limitations; and agreements were viewed as most useful in joint operation of programs or expansion of services for students previously served by another agency. The desire to change and cooperate were noted as the most important element of agreements. The most frequently suggested change for all of the state agreements was that they be written more specifically and clearly. Rural area respondents cited fewer benefits in developing local agreements than staff from urban or suburban areas. (CL)

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A STUDY TO DETERMINE THE EFFECTIVENESS OF LOCAL INTERAGENCY AGREEMENTS AND IDENTIFY THEIR COSTS

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Final Report

September 30, 1981

Prepared Under Grant No. 41-B355-81-3293-7100

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FOREWORD

The Office of Special Education, California State Department of Education was the funding source for this project. The project period was January through September 1981. The findings and conclusions of the study are the sole responsibility of the investigators. The findings do not imply the official position or endorsement of the California State Department of Education nor of the sponsoring agency.

EXECUTIVE SUMMARY

The subject of this study was to assess state and local agreements made between the California State Department of Education and Special Education Service Regions (SESRs) and the "in transition" Master Plan areas with the Departments of Mental Health, Health Services (California Children Services, CCS), Developmental Services (regional centers and state hospitals), and Rehabilitation. California's Office of Special Education developed state interagency agreements with these state agencies to fulfill the requirements of PL 94-142, and it also encouraged SESRs and in transition areas to develop local agreements.

The purpose of this project was to study the perceived usefulness of the agreements and to identify their costs. It also sought to determine whether the agreements imposed additional responsibilities on either the agencies or schools, or changed the quantity or type of service provided.

Five SESRs and five in transition areas were selected for the study sample. They were chosen to include urban, suburban, and rural communities; areas of varying socioeconomic levels and demographic characteristics; areas that had been impacted by a high number of refugees or migrant workers; and areas that provided geographic representation across the state. Personal interviews were conducted in five of the areas, and telephone interviews were conducted in the other five. At each site, both school personnel and staff members from each of the agencies were interviewed.

It was not possible to collect summary data from the schools or agencies on the number and types of special education students served by agency within the sample areas, the types of related service they received, and their cost, but many of the interviewees commented "that business was

going on as usual" or that local agreements "just put down in writing what already had been happening." The schools and agencies usually recorded the types of service a student was receiving on the student's individual education program (IEP) or individual case record, but they usually had not collected summary statistics. The situation was further complicated because all of the agencies in the sample except CCS served all age groups, and the agencies often served a geographical range that was larger than the sample area; sometimes the summary data that the agency had collected did not specify its client's age or place of residence. In other instances where the educational system and an agency were operating a program jointly, only partial information on program cost was readily available from one of the agencies. It was not within this study's time and budget constraints to collect information from individual student's case records. If the Office of Education or other state agencies are interested in collecting cost information without a massive data collection effort, they should direct local staffs to record and summarize it. Data could be collected for each agency on the number of students receiving services, the type of handicapping condition, the type and amount of service they were receiving, and the service cost.

Most of the respondents reported they had not observed any local impact resulting from the state interagency agreements. Some had used the state agreements as a general model when they were developing local agreements, and a few respondents consulted the state agreements when they had questions or were experiencing problems locally. The most frequently suggested change for all of the state agreements was that they be written more specifically and in a style that was easier to understand. Many respondents believed that the state agreements had left important issues such as fiscal responsibility for services unresolved, and they did not want the responsibility of addressing these issues locally. Local agreements were viewed as having limited benefits. Consequently, they were often given a low priority, and most areas had not yet completed them.

All of the SESRs, in transition areas, and agencies avoided including discussions of fiscal obligations in their local agreements because they

were fearful of funding cutbacks and did not want to promise services they subsequently could not afford. During the interviews, it was not clear whether or not the respondents felt particularly bound by either the state or local agreements. Interviewees wanted to provide the best services possible, and they believed it was funding, not the agreements, that would make the big difference. Respondents implied that the agreements would be followed as long as they personally agreed with them and funding was sufficient. Many gave the impression that while local agreements could encourage cooperation and better coordination of services, it was funding levels that would actually make a difference.

One of the chief benefits of a local agreement was reportedly derived from the process of writing it, rather than the content of the final document itself. The process allowed increased communication to occur between the agency and education staff. It also provided a forum for discussing and sometimes solving local difficulties, and helped participants understand each agency's capabilities and limititations. This communication was reportedly more valuable for large urban or suburban areas than for rural areas where staff members of the various agencies either already knew one another or knew who to call when the need arose. Many of the rural staff preferred working with one another informally; they saw no need for a written document.

The other situations where local agreements have the potential for being most useful are when agencies are operating programs jointly (as in the case of Mental Health and Education operating day treatment centers jointly) or when agencies are expanding services to cover students previously served by another agency (as in the case of community education services to State Hospital students). At the other extreme where local agreements may be least beneficial is the Rehabilitation Department which often provides minimal services to high school students; in that situation a memo of understanding or reliance on the state-level agreement may suffice. In the case of CCS, several local CCS staff did not want to develop local agreements because they believed it was important for CCS services to be uniform throughout the state and they thought local agreements would destroy this uniformity.

Policymakers should be aware that the usefulness of these local agreements is at least partly dependent on the staffs' willingness and desire to cooperate with one another. The development of local agreements can easily become paper exercises if participants have no desire to change either their working relationships or the delivery of services; they can simply copy a local agreement from another area or write their own so broadly that it will have no impact. It remains questionable whether the time and effort expended in developing local agreements are worth the ultimate benefits derived from them, particularly in cases such as Rehabilitation, where the local agency is usually providing minimal services to students and in rural areas, where local staffs know one another. In other areas where staff are already working well together, local agreements may also be unnecessary.

In other situations, particularly in large urban areas, a local agreement can be beneficial especially when agencies are operating programs jointly or expanding services to cover students previously served by another agency. In urban areas with many layers of agency bureaucracy, the development of an agreement can serve as a forum for discussing problems and becoming more sensitive to each agency's limitations. However, an agreement will not force cooperation simply because it is written down; the sincere desire to cooperate must also be present. Where local staffs have no desire to change their working relationships or the delivery of services, a local agreement will not be a miracle solution.

It is premature for this study to draw conclusions about the long-term effectiveness of local agreements since most of those completed have been signed only recently. A follow-up study should be done at a later date on agreements that have been finalized for at least 1 year. Such a study could determine whether increased communication continued to occur and whether field staff observed a greater coordination of service delivery or other long term changes as a result of the local agreement. Little will be accomplished if the contents of the agreements are not disseminated beyond their writers. It should also be determined whether greater specificity of

state agreements, including a section on fiscal responsibility, could preclude the need for local agreements.

Until evidence can be found to support their effectiveness in improving services to children, it is recommended that the development of local agreements be optional rather than mandatory. If the agreements are mandatory, many of the SESRs, in transition areas, and agencies will write agreements simply to comply with the law, and money will be wasted on personnel and resources to develop agreements between local agencies simply for the sake of compliance. On the other hand, voluntary agreements will be written because the agencies involved want to use them as a vehicle for increasing communication with one another and improving the coordination and delivery of services to children.

INTRODUCTION

The California State Department of Education has developed state interagency agreements with several state agencies to fulfill the requirements of PL 94-142. That law states that all educational programs for handicapped children, including programs administered by other state or local agencies, are to be under the general supervision of the state educational agency responsible for special education students and should meet the educational standards of the state. The State Department of Education also encouraged Special Education Service Regions (SESRs) and the remaining district and county schools that are "in-transition" Master Plan areas to develop local interagency agreements.

The purpose of this study was to assess the effectiveness and cost of the state and local agreements that the State Department of Education and SESRs or in-transition areas had developed with the Departments of Mental Health, Health Services (California Children Services, CCS), Developmental Services (state hospitals and regional centers), and Rehabilitation to coordinate the provision of services. The study set out to determine the perceived usefulness of the agreements and whether the agreements imposed additional responsibilities on either the agencies or schools, changed the quantity or type of service provided, or changed the cost or responsibility for payment of services. Prior to this study, the Department of Education had not measured the effectiveness of state and local agreements or the additional costs to schools or other agencies.

METHOD OF STUDY

Telephone or personal interviews were conducted in a sample of 10 areas; five areas were Master Plan SESRs and five were in-transition. The sample was chosen to include urban, suburban, and rural communities; areas of varying socioeconomic levels and demographic characteristics; areas that had been impacted by a high number of refugees or migrant workers; and areas that provided geographic representation across the state. Personal interviews were carried out in five of the areas, and telephone interviews were conducted in the other five. At each site, both school personnel and staff members from each of the involved agencies were interviewed. Four of the SESRs or in-transition areas were serving students from state hospitals located nearby; school personnel and staff members from each of these hospitals were also questioned. A total of 93 people were interviewed. Table 1 shows the breakdown by agency.

Table 1

BREAKDOWN OF INTERVIEWEES

SESRs and in-transition Master Plan areas	36
CCS	11
Regional centers	18
Rehabilitation	13
Mental Health	11
State hospitals	4
Total	93

The interviewees from the SESRs or in-transition areas included special education directors and other staff members who had been involved in writing local agreements. If a local agreement with a particular agency had not been started, staff members whose reponsibilities kept them in contact with that agency were interviewed. Agency interviewees were staff members who had helped write local agreements with the schools or were in contact with the school system.

After studying the appropriate state interagency agreements and reviewing materials that the SRI Master Plan staff had collected previously, an interview guide was developed for each agency (See Appendix A). Staff members of each agency and school personnel were asked about the type of relationship they had with the other, how they believed the state agreement had affected services to students in their area, and what type of changes or improvements they would like to see made in the state agreement. Staff members were also asked whether they had developed (or were developing) a local agreement(s), and if not, why not. Table 2 displays the completion status of local agreements within the sample. If agency staff and the school personnel were writing a local agreement(s), they were asked how it differed from the state agreement, whether there had been any problems or areas of discussion or confusion in developing it, and how much estimated staff time was involved in writing it. They were also asked what changes they would like to see in the local agreement. Both the agency and school staffs were asked how useful or beneficial the state and local agreements were and whether they thought it was worth the time and energy expended to write them. Interviewees were also asked about the types of service each agency provided, the number and types of students receiving these services within the sample area, and the cost of each service. The remainder of the report will discuss the findings for each agency separately.

Table 2

COMPLETION STATUS OF LOCAL AGREEMENTS
BETWEEN SESRs,
IN-TRANSITION AREAS, AND AGENCIES - SPRING 1981*

Agency	CCS			Mental Health			Regional Centers			Rehabilitation			State Hospitals		
Sample Areas	Com-pleted	In progress	Not started	Com-pleted	In progress	Not started	Com-pleted	In progress	Not started	Com-pleted	In progress	Not started	Com-pleted	In progress	Not started
Master Plan															
1			X			X			X			X		--NA-	
2		X		X			X			X				X	
3			X		X			X			X			--NA--	
4			X		X			X			X			--NA--	
5		X			X			X						--NA--	
In-transi-tion															
6		X			X			X				X		X	
7		X		X			X							X	
8			X	X					X			X		--NA--	
9		X			X			X						--NA--	
10			X		X				X			X		X	

*This table shows, for example, that Master Plan Area #1 had not started developing a local agreement with either CCS or Mental Health, whereas in Area #2, the local agreement with CCS was in the process of being developed (in progress) and the local agreement with Mental Health had been completed.

NA - not applicable because a state hospital was not located within the sample area.

CALIFORNIA CHILDREN SERVICES

Overview

The state agreement between the Office of Special Education and the California Children Services (CCS) was written to "assure the individual with orthopedic or neuromuscular handicapping conditions the opportunity to achieve a maximum level of physical and educational functioning."* CCS provides diagnostic and treatment services for children under 21 years of age who have severe handicapping conditions that may be arrested, improved, or corrected. Their treatment includes hospital and surgical care, physical and occupational therapy, and orthopedic appliances. CCS is a state controlled agency, but the program is operated by the counties. The state provides 75% of the program's funding and each County Board of Supervisors must vote to contribute the remaining 25%. The state agreement is divided into 11 sections: cooperative program, IEP, material and equipment, physical setting, transportation, individual rights and protection, medical and educational information, confidentiality, interpretation of medical or educational information, qualified personnel, and informed medical and educational staff.

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*Cooperative Agreement Between the Offices of Special Education, State Department of Education and the Crippled Children Service Program, State Department of Health Services, Revised January 1980, P.1.

Perceived Impact of the State Interagency Agreement

When the interviewees were asked about the local impact of the state agreement between the Office of Special Education and CCS, responses varied between "no impact whatsoever" to "overwhelming impact." One school official in a large, urban school district commented, "They took a nothing agreement and sent it to the local level for the locals to work out." In a more positive vein, a physical therapist from another urban area stated, "It continued communication. It's something in writing, even if it doesn't have all the answers." The CCS staff person who reported an overwhelming impact cited increasing numbers of inappropriate referrals for assessments as a result of the agreement.

Many of the respondents had difficulty in distinguishing between the agreement and the problems they were experiencing in delivering appropriate occupational therapy (OT) or physical therapy (PT) to students. It became apparent from the interviews that educators throughout the state are being faced with the situation where CCS decides that a child is ineligible to receive OT/PT through its agency even though a parent may have a private physician's prescription for that therapy. Once CCS has ruled that the child is ineligible to receive its services, the parent may ask that the school provide the therapy. However, the education system does not appear to have an effective evaluation mechanism for examining the efficacy of the prescription. Educators are then left with the choice of either providing therapy by hiring their own therapists; contracting out for services; or denying services, which has the possible consequence of a fair hearing. It is a CCS policy at the state level that CCS must serve its clients totally; it does not allow another agency to provide additional therapy to its clients. If education does begin to provide additional therapy, CCS closes the case entirely.

The education agencies have responded in various ways to the question of providing OT/PT to students whom CCS declared ineligible for service. The large, urban, education agencies tended to hire their own OT/PTs to provide services, while other areas contracted out for OT/PT services.

Three of the areas had done neither of the above--they stood behind CCS decisions and did not provide any OT/PT of their own. The consortium director of one of the areas that did not provide any additional OT/PT said, that so far, he had been able to avoid fair hearings by convincing parents whose children were ineligible for CCS that adaptive P.E. would serve their needs.

CCS staff members in three of the areas commented that they had observed an increase in inappropriate referrals. They attributed this increase to confusion surrounding the agreement. The special education director of one district reported that because of the state agreement, she now asked private doctors of learning disabled students to contact CCS, and she used CCS as a "second opinion" supporting the school's decision that OT/PT would not be beneficial.

Staff members in three areas generally had negative comments about the effectiveness of the agreement. One school staff member said that the state CCS didn't seem to have much control over local CCS agencies, and another said that the state CCS had sent directives out to the locals in a rural area, stating that they were not bound by the state agreement. In the third area, it was CCS staff that complained about the schools who they believed were not following the agreement; in this case, CCS staff reported that the school staff was not discussing the relocation of students, which the agreement states they should do.

When the local staffs were asked about changes they would like to see in the state agreement, the two most frequently mentioned changes were that they wanted an agreement that was:

- More specific and easier to understand.
- Comprehensive enough to resolve the problem of children ineligible for CCS services.

The special education director of a rural area stated that he would like a one- or two-page document listing the responsibilities of each agency. A program specialist in a suburban area wanted the agreement written in more

concrete terms, including examples of services that CCS could provide and others that education was responsible for providing. Other staff members had specific issues that they wanted the agreement to clarify such as:

- A formula for determining the ratio of CCS staff to the number of students served.
- The involvement of both institutions in the IEP process.
- Referrals to CCS.
- Whether or not it is necessary to include the frequency of OT/PT in IEPs.
- Whether or not it is necessary for parents to approve medical evaluations.
- School staff access to CCS records.

Interviewees usually suggested one of two possible solutions to the situation where a child is determined ineligible for CCS therapy and the parents request that the school provide therapy. The first was that the agreement should declare either education or CCS as the agency totally responsible for providing OT/PT, and the second was that if both agencies were going to provide therapy, then the education system should develop an adequate evaluation mechanism for analyzing private physician's therapy prescriptions.

Funding was also a problem related to the agreement. One of the local CCS directors reported that his agency did not have enough funds to implement the state agreement. A special education administrator commented that schools should receive additional funding if they were to be responsible for providing OT/PT. Both education and CCS staffs were concerned about the potential of soaring OT/PT costs if a mechanism were not developed to evaluate the private physicians' prescriptions.

Services and Their Costs

It was not possible to collect adequate summary data from CCS, SESRs, in transition areas, or the other agencies included in this study, on the type and cost of related services being provided to students in the sample areas. In the case of CCS, education agencies were providing the space for Medical Therapy Units (MTUs), their equipment, equipment repair, custodial service, and transportation to and from the unit. However, neither the schools nor CCS had cost data readily available on these items. Neither of the two rural counties in the sample had MTUs within their boundaries.

Local Agreements with Education

None of the school districts had developed a local agreement with CCS, but one consortium and one county education department had local agreements that were reportedly near completion. Two urban school districts were in the process of writing local agreements, and a fifth district had had a meeting to begin initial negotiations. The remaining five had not initiated the process at the time of site visits or telephone interviews in Spring 1981.

Respondents in four of the areas believed that a local agreement between CCS and the local education agency was desirable, while respondents in the another four did not think a local agreement would be beneficial. In two of the areas, interviewees had divided opinions.

Respondents in some areas that were developing agreements did not believe they were necessary, while some of the respondents in areas that had not yet begun developing the agreements believed they would be beneficial. It was apparent from the interviews that children in rural areas were not receiving the same level of services from CCS that they might have received had they lived in an urban area. Neither of the two rural counties in our sample had MTU units within their boundaries. In one, children were transported 50 miles round trip to the MTU unit in another county, and a

program specialist believed students were receiving therapy less frequently than if the MTU had been located nearby. The schools there were not providing any additional therapy. In the other rural area, the county schools were contracting out for some OT/PT services, but CCS was having problems hiring staff, reportedly due to a noncompetitive county pay scale. CCS had tried to contract out for services, in which case the therapists bill the state, but many of the therapists refused to work under this system because they frequently had to wait up to 6 months to receive payment. Some of the interviewees in these rural areas viewed the local agreement as a possibility for improving the services, while others believed that control of the problems were in the hands of state staff or that "local agreements are a waste of time."

Interviewees generally expressed one of four opinions on the usefulness of local agreements between CCS and the education agency:

- The state should improve the state-level agreement, making it more specific, so that there would be no need for a local agreement and so that CCS services would be uniform across the state.
- Local agreements would help iron out local problems.
- The relationship between the local CCS and the education agency was good enough so that a local agreement was not needed.
- A local agreement would not solve the problems they were experiencing.

Some of the staff members who favored a local agreement between CCS and the education agency commented that the process of developing the agreement was more helpful than the content of the document itself. In one suburban area, the CCS senior therapist and a school principal reported that they had gotten to know one another as individuals and learned about the other agency's services as well as limitations. If problems arose in the future, they now knew whom to contact. The CCS senior therapist also reported that he was comfortable with the local agreement they were writing because "it was not too binding with 'nevers' and 'always'." He also liked the fact that it would be possible to revise the agreement later on. Staff members who favored a local CCS agreement but had not yet begun writing one hoped

that it would increase communication between the two agencies, more clearly define each agency's roles and responsibilities, and solve some of the difficulties they were experiencing in coordinating and providing services.

The issue that reportedly caused the most problems when local staffs were developing local agreements revolved around referrals--the type of student who was being referred to CCS and also the procedures by which schools were referring students to CCS. In one area, the subject of who was supervising CCS staff while they were providing services on a school site was raised as an issue. In this area, the schools and CCS staff had developed a draft of the local agreement with which they were satisfied, but the state CCS agency had determined that this local agreement was unacceptable because it allowed a therapist to be sent to a site that had fewer than six children needing therapy. The local CCS staff was considering rewriting the agreement so that it would be in accord with changes at the state level at the time of this study's site visit. The director of the education consortium stated, "If the other agencies can change their mind, then why should we bother to write the agreement?"

MENTAL HEALTH

Overview

The interagency agreement between the State Department of Education and the State Department of Mental Health describes the responsibilities of these agencies at the state and local level in five areas: search, assessment, IEP, individual protections, and administration.

The local, county mental health centers provide a variety of services to all age groups. The state funds most of the program, but the counties operate it somewhat independently. Services include inpatient and outpatient care, partial hospitalization, emergency care, consultation and education, diagnosis, rehabilitation, precare and aftercare, training, and research and evaluation. In addition, services to schools sometimes include day treatment programs for children with emotional problems, which Mental Health operates in conjunction with Education; consultation, education information programs to schools; in-service programs for school staff; and small group counseling sessions at schools. Mental Health uses the Uniform Methods of Determining the Ability to Pay system (UMDAP) to charge its clients for services. UMDAP charges the patient on a sliding scale in accordance with a uniform fee schedule and his/her ability to pay.

Perceived Impact of the State Interagency Agreement

Respondents in nearly half of the sample sites reported they had observed no impact from the state-level agreement between Education and Mental Health. The director of a rural, county mental health office described it as "ethereal" while a program specialist in another area said, "That thing is so loose, it can say anything you want it to. It doesn't give the guidelines that are needed."

The interviewees also raised two major problems revolving around the agreement: one concerned the UMDAP system and the other was psychotherapy. In reference to the UMDAP system, respondents in three of the areas commented that the state agreement appeared to be in conflict with PL 94-142. They believed this because the state agreement directs the education agencies to refer students to Mental Health as needed and directs Mental Health to utilize the UMDAP system on individuals (and therefore charge the parents on a sliding scale). Since PL 94-142 mandates a free and appropriate education for all special education children, educators are reportedly hesitant to refer special education students to Mental Health. They are afraid that education will be asked to pay for either the actual cost of the services or the parent's UMDAP portion of the cost. The situation becomes particularly sensitive when Education and Mental Health are operating a day treatment program together. In some areas, Mental Health waived the parents' portion of the cost, and in others, families continued to be charged.

Several respondents also expressed confusion over the definition, provision, and payment of psychotherapy services and believed that the state agreement should address and resolve the issue. If psychotherapy is to be interpreted as an educationally-related service except when a medical doctor delivers it, as the current state policy declares, then most of the psychotherapy that Mental Health provides would be considered a related service that should be available to special education students free of charge to their parents. However, according to Mental Health regulations, Mental Health may utilize the UMDAP system and charge clients on a sliding scale for any service rendered. The consensus among both the education and mental health staff was that psychotherapy is, in fact, a medical service for which Mental Health should be responsible. The general practice was that regardless of the state agreement and other policy statements, Mental Health is continuing to provide psychotherapy and UMDAP the clients, although at least one district in the sample was contracting for additional psychotherapy services and paying for them from district resources.

Educators were reportedly less willing than they had been in the past to write referrals to Mental Health into the IEPs, for fear that parents would request and insist that the school pay the bill. Several of the Mental Health offices reported a substantial decrease in referrals from education. As one Mental Health administrator stated:

> The intent (of the state agreement) is good, but it is unworkable. It promises more than it can deliver and sets up hopes and expectations. If anything, the agreement has interfered with the delivery of services because the schools are even more afraid torefer to Mental Health. Once it becomes part of the IEP, they are vulnerable.

Respondents frequently suggested that the agreement clarify the psychotherapy issue and specify the services including residential treatment, for which each agency is financially responsible. One children's coordinator for Mental Health, who wanted more specificity on financial responsiblity, also philosophized on the necessary limitations of a state agreement, "Things of day to day substance can't be put on a piece of paper. It is enough for the state agencies to have agreed that they (and locals) will talk with one another."

Services and Their Costs

Neither educational nor mental health staffs could provide summary data on the types and costs of related services provided to school-age children within the sample areas. It was apparent during the interviews, however, that the availability of county Mental Health services varied between areas and even within areas. For example, not all of the county Mental Health agencies operated day treatment centers in conjunction with educational agencies. Among those who did operate such centers, the schools and Mental Health sometimes divided the responsibility of providing the sites for the day treatment centers by having education provide the site for an elementary day treatment program and Mental Health provide the site for the adolescent program. In other cases, Mental Health had assumed the entire responsibility. In one area, the mental health director also reported that his agency

was providing supplies for the program. Mental Health services also varied within areas, partly due to varying community needs and partly due to fiscal constraints. One children's coordinator commented that the agency's funding level allowed it to send consultants only to some of the schools; another commented that the agency was running a day treatment program within only one of their school districts.

Local Agreements With Education

At the time of the site visits and telephone interviews, three of the areas in the sample had completed local agreements between Mental Health and Education, five were in the process of writing them, one had completed initial meetings where the two staffs had discussed writing an agreement but the issue had apparently been dropped, and one area had not yet begun the process. The State Department of Mental Health had required its local staffs to include a local interagency agreement with the appropriate educational agency in its Annual County Mental Health Plan.

Respondents expressed mixed opinions about the usefulness of developing local agreements between Mental Health and Education. Both educators and mental health staff in the two rural counties of the sample believed that the local agreements were not useful to them. In one rural area, where a local agreement had not been written, program specialists commented that they believed a local agreement was not necessary because school staff already were aware of Mental Health services, made referrals as necessary, and were satisfied with the services their students received. The mental health Director stated, "A local agreement is not valuable in a small county where informal relationships work very well. Formalizing it would take away the spontaneity and decrease effectiveness." The other rural county had completed a local agreement, but it reportedly served no purpose. The special education director described it as a "paper thing only," and the mental health director commented, "The local agreement could have been a valuable tool if they (the educators) had said this is what we want and then we could have discussed this, given our resources."

Respondents in the other areas had divided opinions. Many thought that a local agreement between Education and Mental Health was not at all necessary. Those who thought a local agreement between Mental Health and Education would be useful often thought it was necessary when the two agencies were running day treatment programs together. However, not all of the interviewees involved with day treatment centers were sure that such an agreement was beneficial. In some cases, the day treatment centers had been in operation for years and were running smoothly without an interagency agreement. In others, respondents believed that it was the state's responsibility to clarify in the state agreement some issues such as the ones revolving around UMDAP provisions for clients and the definition of psychotherapy that were addressed in the previous section. Educators in one area commented that it was personalities and good working relationships that mattered, not what was put down on paper.

Some of the respondents in two of the large urban areas in the sample did describe some general benefits from developing the local agreements. A school administrator in one district believed the process of getting together to write the agreement had given staffs an opportunity to share philosophies and therefore realize "we are in the same boat serving kids"; he also thought it would facilitate delivery of services. In the other urban district, a school administrator commented that while he did not think a local agreement with Mental Health was necessary, the process of developing one had increased the staff's understanding of each other's referral procedures, and in-service training sessions had been planned. Another administrator from the same area philosophized about the difficulty of putting a local agreement into practice:

> The concept of local agreements is sound--it is logical to define who is responsible for what tasks, under what conditions, and who will pay. They help avoid duplication and promote a least restrictive environment (LRE). But what do we have to give the agreements credibility? Negatives come from increased expectations from the written agreements and disappointments that happen when agencies are faced with fiscal constraints and cutbacks.

There were several issues that interviewees reported discussing during the development of local agreements. All of the areas that had begun

negotiations on the agreement reported discussing one aspect or another of financial responsibility for services. The implications of the UMDAP system and general responsibility for services were reportedly discussed in many of the areas, while two areas specifically mentioned financial responsibility for assessments, referrals, or psychotherapy. Mental health staff in two of the areas also commented that two results of the interagency negotiations would be increased awareness that Mental Health funding was shrinking, as well as requests from educators for equal services to schools throughout an area, which was not possible given Mental Health fiscal constraints.

The consensus among most of the interviewees was that the financial responsibility had not been satisfactorily resolved during their discussions. Some of the interviewees reported they had purposely avoided financial matters in the local agreements or addressed them very generally, while the mental health staff of one area believed the reason nothing had been written down yet was that the schools did not want to make themselves financially liable for anything in writing.

The other major topic of discussion in developing the local agreements involved the process by which students were placed in Mental Health programs. Staff in several of the areas reported that there had been--or needed to be--discussions on referral procedures, eligibility criteria, and timelines for placing students in Mental Health programs.

Other miscellaneous problem areas identified through the interview were the confidentiality of records, duplication of counseling services that the schools and Mental Health offered, and confusion over definitions regarding eligibility and services. In the last instance, a school administrator commented that this confusion had caused people to believe that they were in agreement when they were discussing and writing the local agreement, but that they disagreed when they were actually discussing services for a particular child.

REGIONAL CENTERS

Overview

The state agreement between the Department of Education and Department of Developmental Services (regional centers) describes the responsibility of each agency at the state and/or local level. The agreement is divided into nine areas: child find, information exchange, assessments, IEP/IPP (Individualized Program Plan), infants and preschool, specialized equipment, rights and protections, client relocation, and administration.

Regional centers serve people of any age who have developmental disabilities that include handicapping conditions such as mental retardation, cerebral palsy, epilepsy, and autism. There are 21 private, non-profit organizations located throughout the state of California. Their services include information and referral, diagnosis and evaluation, and advocacy. They may also purchase needed services if there is no other source of funding.

Perceived Impact of the State Interagency Agreement

When the school administrators and regional center staff were asked to discuss the impact of the state agreement at the local level, the general consensus was that it had had no major impact. Some of the regional center staff and special education administrators mentioned that they had met with personnel from the other agency to discuss the state agreement after it was released, and others mentioned that the state agreement either had been used or would be used as a guide when they wrote the local agreement. Both regional center and school staff members, in one rural in-transition area, commented that it had helped clarify issues and responsibilities; they had

referred to the original interagency agreement, which defined physical therapy, occupational therapy, and speech therapy as related services that education should provide. In another Master Plan area, however, a program specialist reported that local staff in her district still needed to come to a clear understanding of the state agreement's meaning. Local staff had called the State Departments of Developmental Services and Education with questions and had gotten different interpretations, even within each department. After that occurred, she reported that "people just put the agreement aside and ignored it."

There were two other areas where respondents reported overlooking parts of the agreement. In one large, urban Master Plan district, school staff reported disregarding the part that states that schools shall invite regional center staff to their clients' IEP meetings. Some of the school staff believed this invitation should be the parent's responsibility and that it would be a bureaucratic hassle to inform the regional center in writing about each of its student's IEP meetings, also renotifying them each time a meeting was rescheduled. The special education administrator reported that one of the regional centers agreed on this issue, and the schools were not notifying the regional center about IEP meetings.

The other area that reported overlooking parts of the agreement was a rural, MP area. The special education director there stated that the local regional center was not following the state agreement in terms of due process and keeping the schools informed; the schools were not being invited to participate in regional center meetings where the children's IPPs were being developed.

Staff from the remaining areas had both positive and negative comments about the state agreement. Some of their comments were:

- "The state agreement has not convinced people who is responsible for related service, but it has set up a concrete network of communications. Once people start talking, the rest falls into place."
- "All it says is that we will mutually share information and notify each other of IEP and IPP meetings....It doesn't have any teeth in it."

- "It may possibly give (the regional center) a little more entree into the schools."
- "It doesn't really say anything."

When the interviewees were asked how they would like to change the state interagency agreement, staff members from both agencies in half the areas commented that it needed to be more specific. Interviewees in over one-third of the areas reported that it was difficult to understand. One regional center administrator commented that he thought it might have been written obliquely because the authority of education was at the local level, and the State Department of Education didn't want to tell the locals what to do. A regional center staff member from another area also felt that there needed to be stronger directions from the state; he stated, "Some counties (education systems) ignore anything they want to."

Services and Their Costs

Neither the regional centers nor the SESRs or in transition areas could provide summary data on the number or type of school-age children the regional centers were serving in our sample areas, the type of services provided, and the cost of these services. The situation was somewhat complicated from the regional centers' standpoint because they serve all age groups and may also serve several counties; at the other extreme, one large urban school district was being served by several regional centers. Some of the regional centers were in the process of developing computer systems that would have the capability of providing summary information, but they were not yet operational. The schools generally kept this kind of information only on individual IEPs and did not aggregate it for reporting purposes.

When the school personnel and regional center staffs were asked about the services provided by the regional center, reports varied between areas and even within areas. Some staff reported that their regional center no longer provided any speech therapy, occupational therapy, or physical therapy to school-age children, while others reported that they provided "a

little" or they provided "some during the summer months." The director of a regional center in a rural area commented that the center bent the official policy somewhat in order to see that its clients were served; as long as a family was in the process of a fair hearing, the regional center would provide the services that the schools were supposed to be providing.

Local Agreements with Education

Two of the areas in our sample had completed local interagency agreements with the regional centers, five were working on them, and three had not yet begun. All of the staff members, who commented on the difference between the state and local agreements, reported that the local agreement was more specific. Interviewees stated, "It's more definitive," "it sets up procedures on who to contact," and "for referring staff, it discusses what is available and how to go about getting it."

Staff members reported several problem areas that had either been discussed and addressed during the development of the local agreement or were ones that should be addressed, if a local agreement subsequently was written. Several staff members reported a problem regarding confidentiality of records and the exchange of information. Another common discussion topic was the advocacy role of the regional center and the its staff involvement in classroom visitations, IEP meetings, and educational placement decisions. Staff from two areas specifically reported discussing appropriate versus optimal placement, and a special education administrator from another area reported discussing the fiscal limitations of both agencies. The notification of IEP and IPP meetings was also a matter of concern in two areas: (1) the schools wanted a mechanism to ensure that they were made aware of which of their students were regional center clients, and (2) the regional center wanted a mechanism to know when its clients' IEP meetings were scheduled at the school site, so that a caseworker could attend. In a large urban district served by several regional centers, the district and regional centers had not yet come to an agreement on a procedure for notifying one another of IEP and IPP meetings so they had left the wording in the agreement "rather loose."

Other problem areas that were reported less frequently than those reported above were:

- The role of foster care parents at IEP meetings.
- Notification when students were no longer going to be living at home, and the regional center was arranging out-of-home placements.
- Regional center versus Master Plan timelines for evaluations and IEP meetings.

When the interviewees were asked to discuss the usefulness of local interagency agreements, the responses were varied. Both education and regional center staff, in the two rural areas of the sample, had not written local agreements and did not see a need to write them. The director of one of the rural regional centers believed it would take more time than it was worth, especially in a small community where the staff members knew each other and saw one another around town. One of his staff members commented that the center was "already living the spirit of the agreement," but he added that a local agreement probably would be needed if the two agencies developed a joint infant program and "began mixing funding and authority," which they were considering. The child rights' advocate of the other rural regional center in the sample believed that while local agreements were ineffective as practiced, they did have the potential to be effective. He had helped write a local agreement with a rural county outside the sample and reported it was a paper product; business was going on as usual. He did report that "we might fall back on it if things got tough and we had to bolster our position."

In the two Master Plan areas that had completed local agreements between the education agencies and regional centers, response to the question of their effectiveness was somewhat more positive, but it was by no means unanimous. In one suburban area, the agreement had been completed in July 1980. Both regional center staff and the education staff reported that developing the agreement had opened up communication channels and encouraged cooperation. One of the program specialists also believed that duplication of assessment had decreased as a result of the local agreement, and the regional center education liaison believed it had opened up expeditious

services to students. On a somewhat negative note, one of the school administrators and another program specialist expressed concern about what happens to an agreement after it is written. The program specialist believed that in-service training on the substance of the agreement had been inadequate. Principals from county-operated schools had attended an in-service meeting and were supposed to go back to their schools and explain it to their staff. The specialist's principal had been a weak link in the chain, and he hadn't told his staff anything. The county was also concerned about the effectiveness of the agreement and was conducting a survey of principals, support staff, regional center staff, and parents.

In the other area that had completed a local agreement, the regional staff interviewees were quite negative about the effectiveness of local agreements. The unit manager stated:

> An inter-working relationship between agencies is not gained by writing something down, that depends strictly on who's in charge, what funding crisis each agency is facing, and key individuals within the agency. The only time you want one (local agreement) is when things are lousy. The hope is that when you sit down and talk, things will get better. The paper (local agreement) won't fix it, but maybe talking will.

Another regional staff member stated: "An agreement reflects what's already going on, no more, no less." He would have preferred to have an agreement that was a statement of philosophy, emphasizing mutual responsibility for clients rather than a division of responsibility, which the current agreement emphasized. One of the education staff, who had helped write the agreement, felt that it had been worthwhile for staff members of each agency to learn about the other's problems and limitations, but she was not sure whether more or improved services to students would occur as a result of the agreement.

Staff from two of the large urban school districts that were in the process of writing local agreements commented on the development of a better communication network. The regional center staff in one of the areas was hoping that as a result of the local agreement, the regional center would be able to bypass the downtown school administration and contact

prinicpals or other staff directly. On the other hand one of the school administrators in the other urban area really wasn't sure whether the agreement was worth the time and effort it took to write.

Comments from regional center staff in two of the other areas that were developing agreements are also enlightening. One regional center staff member commented that, "The fruitfulness is working out the agreement," and the other stated

> As the draft stands now, it is so general that it will be of no help to anyone. In order to be effective you need to say who is responsible for what services and who will pay. The schools are afraid of being stuck with a big bill though, so they don't want this down on paper. They want it decided on a case by case basis.

VOCATIONAL REHABILITATION

Overview

The state agreement between the State Department of Education and the State Department of Rehabilitation covers four main areas: client find (search), assessment, program replacement/review/implementation, and administrative policies. In each of these areas, the agreement describes the general responsibilities of the State Department of Education, local education agency, State Department of Rehabilitation, and local department of rehabilitation district. The department of rehabilitation serves adults as well as youths, and the program is state operated.

Perceived Impact of the State Intgeragency Agreement

When the interviewees were asked about the impact of the state agreement at the local level, the general consensus was that it had not made an impact or affected services one way or the other. However, some of the rehabilitation staff did feel it was beneficial. For example, one administrator commented, "The state agreement sets the tone within the district. It gives general guidelines, approvals to do certain things. In a bureaucracy, it is difficult for people to take over or give up certain responsibilities without something of this nature." Another rehabilitation administrator commented that it was a statement of the department's philosophy. He was referring to the agreement in an effort to convince his supervisor that the department should serve 9th and 10th graders instead of waiting until they graduated from high school. However, the rehabilitation department generally provided minimal services to high school students in the sample areas.

Alternatively, some local education and rehabilitation staff members believed that the state agreement was useless without adequate funding. One of the representative comments was:

> Dollars are really the big issue; once the dollars run out that's it...both Education and Rehabilitation have gone through funding crises; the funding is not there to carry out the activities.

The interviewees did not make any suggestions for changing or improving this agreement at the state level. This is probably because they had felt no impact from it and were content to leave well enough alone. There were several other factors that may also have influenced their complacency. As will be discussed below, Rehabilitation faced funding cutbacks during the fall of 1980 and was generally providing minimal services to high school clients. Both staffs gave the impression that Rehabilitation would provide whatever services it could, given the fiscal constraints, and an interagency agreement was powerless to affect these fiscal contraints.

Services and Their Costs

With the exception of one school district, the rehabilitation offices and the schools did not keep central records on the number of high school students Rehabilitation was serving, the types of service provided, or the cost of the services. The rehabilitation offices did not have a breakdown of its clients by age, and the school districts usually kept track of this type of information only on individual IEPs.

Half of the areas reported that the only rehabilitation service that was usually provided to high school students was counseling and vocational planning during the spring semester of their senior year. In one rural area, the rehabilitation counselor reported that he hadn't had any high school referrals during the 1980-81 school year. The remaining four areas reported varying levels of rehabilitation services. The one school district that did have data on the number of high school students who were rehabilitation clients reported 150 open cases. This was an unusually high

number; in this large, urban school district, the district paid employers for the students' training and then Rehabilitation reimbursed the district. However, in the future, the school district was not going to be reimbursed but planned to continue the program anyway. In one of the other areas, Rehabilitation was phasing out a work experience program for 11th and 12th graders that had been in place for several years, and in another, Rehabilitation and a special education, vocational assessment center run by the school district were reportedly competing for clients. In the last case, a rehabilitation counselor stated that the agency was capable of serving more high school students than were currently being referred, but a school representative reported that the Department of Rehabilitation had taken up to a year to interview school referrals.

Almost all of the rehabilitation personnel commented on the financial cutbacks they had faced recently and the decreasing amount of services they were able to provide high school age clients. In a couple of areas, staff members commented that the rehabilitation counselors' caseloads were extremely high; and consequently, if a student missed an appointment, the case was automatically closed, whereas in the past, the rehabilitation counselor would have called again to set up another appointment. Other staff members commented on work study programs that had been phased out and decreasing expenditures for specialized equipment. For the most part, Rehabilitation was offering only minimal services to high school clients. Given their fiscal constraints, this may be all they are realistically capable of providing.

Local Agreements with Education

Three out of the 10 SESRs and in-transition areas had completed local interagency agreements with Rehabilitation, four of the areas were working on them, and three had not yet begun. Two of the areas in the process of developing local agreements had reached impasses. In one, the consortium director was, at least temporarily, refusing to sign the agreement because Rehabilitation was phasing out its work experience programs for 11th and

12th graders; he stated, "It appears that everyone wants to pull out and leave the public schools holding the bag." In the other area, an agreement had been drafted, but both the rehabilitation administrator and the work study coordinator for the school district commented that the assistant administrator for special education was holding it up, probably in an effort to protect the district's special education, vocational assessment center.

Of those areas that had completed local agreements, personnel in two large, urban districts commented that one important discussion topic during the development of the agreement had been the procedure by which the schools would send appropriate records to Rehabilitation. One of these areas also reported that the schools had wanted a feedback mechanism so that they would know what had happened to their referrals; there had also been a great deal of discussion over what procedures a rehabilitation counselor should follow before entering a school campus. In that area, school administrators reportedly did not want rehabilitation counselors entering campuses unannounced for three reasons:

- Security problems on campus.
- The schools' vocational education department wanted control over who was talking with their students.
- There had been a problem in the past when a rehabilitation counselor met with a student in the cafeteria, and no one knew where the student was. The parents had panicked, and the police had been called to search for the student.

Both agencies wanted to avoid the recurrence of this type of situation, but the interviewees did not agree on the manner in which it had been resolved.

School staff and rehabilitation staff expressed a wide range of opinions when they were asked about the usefulness of local agreements between the two groups. Neither of the two rural areas in the sample had started writing an agreement, and neither of them saw a need to. Rehabilitation was providing minimal services in these areas; for example, in one office there were two rehabilitation counselors covering two counties. One counselor stated, "The relationship between the staff is far

more important than anything put on paper. The staff know each other here." In one of the other areas that had not started writing an interagency agreement, Rehabilitation did have memoranda of understandings (M.O.U.s) with particular high schools. The rehabilitation administrator there preferred to have M.O.U.s with high schools rather than interagency agreements with school districts or consortiums because he believed M.O.U.s were less bureaucratic and more efficient. In the last area that had not started an agreement, the rehabilitation counselor believed it would be useful to share ideas and develop an agreement, but the rehabilitation district administrator commented that paper doesn't make the relationship. He also stated, "We don't need a piece of paper to talk to each other, all it does is prove to someone in Sacramento that we've done it...In dwindling resources, agreements won't be adhered to."

In areas where agreements had been completed, respondents generally believed that either the process of developing the agreement had increased communication and understanding between the two groups or that the paper didn't mean much. Some of the comments were:

- "Developing a local agreement makes people get to know each other, makes them aware of what others are doing...However, once the money runs out, that's it."
- "Instead of having problems go unresolved, we discuss them...Rehab is getting better referrals now."
- "Agreements are so general nobody pays any attention to them; you can pull them out when there's trouble though."
- "We don't have a cooperative program with the schools (that is, work study like we used to) so we don't really need anything to be written down."

STATE HOSPITALS

Overview

The state hospital interagency agreement describes the responsibilities of the Office of Special Education, County Education Agency, State Departments of Developmental Services and Mental Health, and local state hospitals for delivering appropriate educational services to state hospital clients. The agreement is divided into eight areas: technical assistance, professional development plans, IEPs, compliance, individual protections, least restrictive environment, communication, and funding. This state agreement is unique because it mandates local agreements.

Four of the 11 state hospitals were included in our sample. Two of them provided services exclusively to the developmentally disabled, and two provided services to both the developmentally disabled and the mentally disabled. The hospitals are state operated.

Perceived Impact of the State Interagency Agreement

When the interviewees were asked about the impact of the state-level agreement on state hospitals at the local level, most of them reported that it hadn't had much effect. One education director at a state hospital commented that, "It is general enough that specific impacts are not felt at the local level. It's the law that makes the impact, not the agreement." A staff person at another hospital reported that it was not part of her everyday life, but if they had not had a good relationship with the county, she thought they would have relied on it. She believed it set the stage for negotiations, particularly if the parties did not know one another. The assistant chief of central program services of one of the hospitals did

think the agreement had made an impact, however. He believed the agreement had increased paperwork because the hospital had had to rewrite local policy and change some of its forms to comply with it.

Local Agreements with Education

AB1202 states that the County Education Agency shall assure a community public education to all school-age state hospital clients for whom the IEP meeting determines that community placement is appropriate. It also stipulates that the state hospitals and County Offices of Education cooperatively should work out local agreements covering services provided to state hospital residents through community placements.

All four of the state hospitals and the education agencies associated with them had spent many long, hard hours developing a local agreement and all of them were near completion. Two areas had written more than six drafts of their local agreement, and three areas reported submitting agreements to the State Department of Developmental Services. In each case, the state department had sent the agreement back to the local staff, requiring revisions. In one instance, the revisions were mostly format rather than substantive changes, and in another area, the State Department of Developmental Services reportedly had wanted some technical information that the locals hadn't believed to be necessary. Several staff members commented that if it hadn't been for the State Department of Developmental Services, the locals would have reached an agreement long ago.

Interviewees from each of the areas spoke about problems they had had in developing the local agreements. The education director of one of the state hospitals said, "AB 1202 is short enough that there are ambiguities in it when you get down to working out the nitty-gritty." Interviewees from the areas that were expecting more hospital clients to be served in community placements expressed more problems in developing the local agreements than areas that were expecting smaller numbers of community placements. Respondents from the area that expressed the fewest

difficulties had between three to eight students being served by the local school district (state hospital and education staff estimates varied), and the staff from the hospital expected there would not be any community placements in the future because the hospital was not going to be serving developmentally disabled youth. In this area, there had been discussions about the different assessments that the schools and hospital used, and the procedures for completing service contracts that would enable the school district to be reimbursed for the hospital students it was serving and also for the county representative who was sitting in on the state hospital clients' IEP meetings.

In the remaining three areas, where one hospital estimated there would be 53 community placements and the other two estimated 130 community placements each, funding was reported as the major concern. The education agencies all wanted to be reimbursed according to the actual costs they incurred for educating and transporting the hospital clients rather than being reimbursed according to a state average because they believed their costs were higher then the calculated average. The local state hospital staffs were sympathetic with this viewpoint and agreed that the school districts should be reimbursed fully. This was a matter that had to be resolved at the state level, but a final determination had not yet been made when the locals were writing their own agreements, and consequently it caused much concern.

Both of the state hospitals that were expecting 130 community placements reported lengthy discussions regarding in-kind services (that is, trading staff members), transportation related issues, and attendance at IEP meetings. Staff members of both hospitals expressed some concern about resolving differencees of opinion between the two agencies at IEP meetings. The education director at one of the hospitals reported that there had been a great deal of discussion about who should attend IEP meetings and where they should be held. She believed the school district staff was afraid of being outnumbered at the meetings even though decisions would be made by consensus. A staff member from the other state hospital reported that one of the big issues in developing its local agreement had been the role of the

interdisciplinary (ID) team from the state hospital at IEP meetings, and how a disagreement between the ID team and the parent and county education representative would be resolved. The issue had not been discussed fully at the time of the interview for this project.

One of the areas also had discussions on the logistics of having a county or district representative at every IEP meeting (they decided they needed two county people in this role), appropriate placement versus the least restrictive environment, and the role of psychiatric technicians in the classroom.

The education director of the other state hospital that anticipated 130 placements reported that staff members of the nearby school district did not believe they should serve state hospital students, but at least "they were saying the right words now." The state hospital's education director also reported that prior to AB 1202, this school district had taken pupils only when they had openings and needed the average daily attendance. In developing their local agreement, staffs in this area had discussed proper credentialing of the district's teachers and the quality of services, particularly speech therapy, that hospital clients would receive in the community.

The interviewees of both the educational agencies and state hospitals expressed more support for the development of these local agreements than staff of the other agencies reviewed in this study, possibly because the relationship between the state hospitals and schools was changing, and it was going to be necessary for the state hospitals to work more closely with the schools than most of the other agencices. The staffs had experienced many problems in their efforts to develop the local agreements but they usually believed the agreements would help ensure appropriate community placements for those state hospital clients who could benefit from them. The education director from the state hospital that was associated with the least cooperative school district believed the development of a local agreement was worthwhile because it had opened up communication and "helped us focus on specific issues systematically, rather than waiting until they

are at the crisis stage." A special education administrator from that area commented, "It gives the nuts and bolts on how to do everything," and a staff member from another state hospital said, "The more thorough we are in developing the local agreements the more problems we will forestall." On the other hand, the chief of program services at one of the other hospitals did not want the local agreement to become too specific because he wanted the flexibility to deal with unusual cases, and a staff member from the state hospital that expected the fewest community placements commented that a simpler format would have been sufficient in cases like his, where so few students were involved. He believed that "returns from a local agreement become less and less as you deal with smaller groups of people."

SUMMARY AND RECOMMENDATIONS

Most of the respondents from the education agencies and other agencies in the sample (CCS, regional centers, Mental Health, Rehabilitation, and state hospitals) did not report any observable local impact as a result of the state-level agreements. Some had used the state agreements as a general model for developing their own local agreements, and others reported consulting a state agreement occasionally. The most frequently suggested change for all of the state agreements was that they be written more specifically and in a style that was easier to understand. Many of the respondents believed that the state agreements left important issues unresolved, and they did not want the responsibility of addressing them in local agreements.

Local agreements generally were viewed as having limited benefits. Consequently, they were given low priority, and most areas had not yet completed them. Many of the respondents commented that the process of developing them was more useful than the actual document that was produced. The process gave the educators and agency staffs an opportunity to know one another as individuals; it reportedly increased communication and helped the participants understand each agency's capabilities and limitations.

Interviewees in the rural areas of the sample saw fewer benefits from developing local agreements than staff from suburban or urban areas. In the rural areas, staffs either knew one another personally or knew who to call when the need arose. They often preferred to work with one another informally rather than developing an official agreement.

Local staffs from all agencies were extremely reluctant to include anything in the local agreements that had monetary obligations or implications; staff members from all of the agencies interviewed were

fearful of funding cutbacks and did not want to be obligated to deliver services they could not afford. During the interviews, it was not clear whether or not the respondents felt particularly bound by either the state or local agreements. Interviewees wanted to provide the best services possible, and they believed it was funding, not the agreements, that would make the big difference. Respondents implied that the agreements would be followed as long as they personally agreed with them and funding was sufficient.

Interviewees also expressed the viewpoint that local agreements were more useful when agencies were sharing the provision of services to students directly (as in the case of Mental Health and Education operating day treatment centers jointly) or when agencies were embarking on the delivery of new or expanded services (as in the case of community educational services to State Hospital students). However, several of the local CCS staff did not want to develop local agreements because they believed that it was important for CCS services to be uniform across the state and that local agreements would destroy this uniformity.

It is clear that the development of local agreements can easily become a paper exercise in which other local agreements are copied or modified slightly, and problem areas are ignored. Thus, it remains questionable whether the time and effort expended in developing local agreements are worth the ultimate benefits derived from them, particularly in cases such as Rehabilitation, where the local agency is usually providing minimal services to students. In these cases, a memo of understanding or reliance on the state-level agreement may suffice. In rural areas, where local staffs know one another and in other areas where staff are already working well together, local agreements may also be unnecessary.

In other situations, particularly in large urban areas, a local agreement can be beneficial especially where local education agencies will be responsible for serving increasing numbers of state hospital students or where Mental Health and Education are jointly operating day treatment centers. In urban areas with many layers of agency bureaucracy, the

development of an agreement can serve as a forum for discussing problems and becoming more sensitive to each agency's limitations. However, an agreement will not force cooperation simply because it is written down; the sincere desire to cooperate must also be present. Where local staffs have no desire to change their working relationships or the delivery of services, a local agreement will not be a miracle solution.

It is recommended that local agreements be voluntary until a follow-up study can be performed on the effectiveness of local agreements that have been in place for at least 1 year. This proposed study could determine whether increased communication had continued to occur after the agreement had been implemented and whether field staff observed more effective referral procedures and service delivery as a result of these agreements. Little will be accomplished if the contents of the agreements are not disseminated beyond their writers. It should also be determined whether greater specificity of state agreements and a section in them that includes fiscal responsibility, could preclude the need for local agreements.

Summary data from the agencies on number of school-age children served within the sample areas, type of services provided, and cost were not available from SESRs, in-transition areas, and agencies in the study sample. Useful data would include the number of students in each handicapping condition that are receiving services from each agency, the type and amount of service they are receiving, and service cost. If the State Department of Education or other State Departments wish to collect this information without an independent, massive data collection effort that would involve the examination of individual IEPs and case records, the local agencies will have to be directed to record, summarize, and submit the information as part of their general reporting activities.

Interview Guide*

General

1. Is there someone responsible for developing and monitoring interagency agreements? Does one person cover all agencies or is there a different person for each agency/agreement? If not, why not? (cost, time,etc.?)

California Children Services (CCS)

1. What is the district's (county's/SESR's) general relationship with CCS? Are there any problem areas in particular?

2. How do you think the state CCS interagency agreement has effected services in your area?
(If no effect, ask: How has your relationship with CCS changed over the last couple of years?)
How has fiscal responsibility for services changed?
How has the quantity/quality of services changed?

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*These questions are worded for SESR or intransition staff. Agency staff were also asked these questions, although it was necessary to rephrase some of questions. For example, the first question for CCS staff was "What is CCS's general relationship with the district" and question #3 was "Do you have a local agreement with the district?"

3. Do you have a local agreement with CCS?
(If no: are you planning on writing one?)
If yes: May I have a copy?
How does it differ from the state agreement?

When and why did you write it?

Approximately how much staff time was involved in writing the agreement?

What are the particular problem areas of the local agreement?

4. Who is paying for OT/PT now? (equipment, salaries, transportation, other)

How much does it cost (equipment, salaries, transportation)

How many students are receiving OT/PT?

How many therapists are there part-time/full-time?

How many paraprofessionals or aides assist the therapists? (Who pays their salaries?)

What is the therapists salary per hour?

What is average OT/PT cost per student?

How were the OP/PT costs handled in the past?

Do you expect them to change in the future?

Does the family's medical insurance (if they have it) or Medicaid (if they are eligible) pay for OT/PT? If not, why not? (it would cost the parents nothing in both of these cases).

5. Who is paying for the Medical Therapy Unit(s)?

Estimate cost for each: Equipment

Equipment repair

Custodial service

Space for unit.

How many medical therapy units are there?

Has fiscal responsiility for the Medical Therapy Unit changed during the past couple of years?

6. As integration into regular programs increases how does this effect the usefullness of the units located at one school site? (Impact on therapy costs and quality of treatment)

Is transportation to and from the medical unit difficult to arrange? Yes___, No___

Who is responsible for making the arrangements?

Cost estimate of transportation? (Who pays?)

Are students generally receiving the same level of services as they did prior to mainstreaming? Yes___, No___

Has it been necessary for CCS to increase the number of itinerant therapists because of integration into regular classrooms? Yes___, No___

(If yes, How many therapists and have services at Medical Therapy Units been decreased?)

7. Are there other services that CCS provides but bills the schools or other agencies for? (get details.)

8. Do you keep records of referral to CCS?

Do you keep records of assessments?

9. Have referrals from schools to CCS increased or decreased in recent years?

   Get estimates of number of referrals--How does this effect CCS's budget?

   Has CCS had to change its diagnostic or treatment capabilities?

   How long does it usually take CCS to provide diagnostic services? (Does school go elsewhere for diagnosis?)

10. How would you like to see the state (or local) agreement with CCS changed?

11. What percentage of your budget comes from federal_____

    state _____

    local _____

Regional Centers

1. What is the district's (county/SESR) general relationship with the Regional Center? Are there any problem areas in particular?

2. How has the state interagency agreement on Regional Centers effected you? (If no effect-ask: How has your relationship with the Regional Center changed over the last couple of years?)
   How has fiscal responsibility for services changed?
   How have the quantity/quality of services changed?
   Do you see any trends or changes in the near future?

3. Do you have a local agreement with the Regional Center?
   (If no: Are you planning on writing one?)
   If yes: May I have a copy?
   How does it differ from the state agreement?

   When and why did you write it?

   Approximately how much staff time was involved in writing it?

   What are the particular problem areas with the local agreement?

4. Besides diagnosis and case management, what services does the regional center provide?

   Counseling?
   If yes, does the family's medical insurance (if they are covered) or Medicaid (if they are eligible) pick up a portion of the costs? What do you think of that possibility?

   - OT/PT?

   - Speech Therapy?

   - Respite care?

     Summer camps?

   - Parent training?

- Residential costs related to non-public school placement and licensed children's institution? (under what conditions: when placement is necessary for other than educational reasons? Does the regional center cover all/part of the costs?)

- Equipment: under what conditions? Does the school provide specialized equipment as long as it is not for the exclusive use of any one individual at the school site?

  Does the regional center provide equipment not covered by CCS?

- Other?

Do you expect these services to change? (Have they changed recently?)

Get the number and types of students served, salary, equipment, and transportation costs for each service.

5. Do you keep a record of the number of referrals to the Regional Centers?

6. Has the regional centers caseload and referrals from schools increased, decreased, or remained about the same over recent years? If there has been a change, how would you explain the change and how has the Regional Center reacted?

7. What would you like to see changed in the state(or local) agreemeent with Regional Centers?

8. What percentage of your budget comes from federal_____

   state _____

   local _____

Department of Rehabilitation (Rehab)

1. What is the district's (county/SESR) general relationship with the Department of Rehab? Are there any problems in particular?

2. The Department of Rehab can alter priorities and cut off service when there are insufficient funds. How has this effected services in your area?

3. What services does the Department of Rehab provide for students in your area?

	Number and types of students	Cost (to whom)
Assessment		
Occupational Skills Instruction		
Counseling		
Aids/devices (individually owned)		
OP/PT		
Speech correction		
Job development and placement		
Tools (indiv.owned)		
Transportation		
Family support services		
Other related services (list)		

Has the provision of services changed recently or do you expect any changes?

4. What impact do you think the state agreement with Rehab has had in your schools?
(If none, ask: How has you relationship with Rehab changed over the last couple of years?
How have the services or payment for services changed?)

5. Do you have a local agreement or contract with Rehab?
(If no: Do you plan on writing one?)
If yes: May I have a copy?
How does it differ from the state agreement?
When and why was it written?

Approximately how much staff time was involved in writing the agreement?

What are the particular problem areas of the local agreement?

6. What changes would you like to see in the state (or local) agreement with Rehab?

7. What percentage of your budget comes from federal_____

state _____

local _____

Mental Health

1. What is the district's (county/SESR) relationship with County Mental health? Are there any problems in particular?

   (Ask Mental Health people: We realize that community mental health programs differ from place to place. What sorts of services do you provide? Do you expect any change in the near future?

   _____Day treatment programs (offer ed. programs? ___yes ___no)

   _____Consultation, education, information progams

   _____Training and in-service programs for school personnel

   _____Small group counseling sessions in schools

   _____Other: get details

2. Which services does Mental Health pay for and which does the schools pay for? (get breakdown of type of service, estimates of number of students served, types of student and dollar amounts)

   Has this changed from the way things were done in the past, and do you expect them to change in the future?

3. What impact do you think the state agreement with Mental Health has had on the schools in your area?

   (If none,ask: How has your relationship with Mental Health changed over the last couple of years?
   How has fiscal responsibility for services changed? (get specific--type of service, number of students, cost)
   How have quantity/quality of servicess changed? (get specific--types of service, number of students, cost)

4. Do you have a local agreement with County Mental Health?.(If no: Do you plan on writing one?)
(If no: Do you plan on writing one?)
If yes: May I have a copy? How does it differ from the state agreement?
When and why did you write it?

Approximately how much staff time was involved in writing the agreement?

What were the particular problem areas with the agreement?

Cost implication of the agreement?

5. Does the family's medical insurance (if they have it) or Medicaid (if they're eligible) pay for all or part of the counseling costs?

If not, why not? This would cost the families nothing, and school districts would also be relieved of responsibility for a portion of the costs.

6. Do you keep records of referrals to Mental Health?

7. Have school referrals to Mental Health's day treatment centers increased, decreased, or remained about the same over recent years?

If there has been a change, how would you explain it?

8. How would you like to see the state (or local) agreements with Mental Health changed?

9. What percentage of your budget comes from federal_____

state _____

local _____

State Hospital (Ask County Offices these questions)

1. What is the district's (county/SESR) general relationship with the state hospital? Are there any problem areas in particular?

2. How has the state hospital interagency agreement effected you? (If no effect, ask: How has your relationship with the State Hospital changed over the last couple of years?)

3. Do you have a local agreement or a cooperative program with the State Hospital?
(If no: Do you plan on writing one?)
If yes, May I have a copy? When was it written and what does it cover?

Approximately how much staff time was involved in writing the agreement?

How does it differ from the state agreement?

What impact has it had on the provision of services and fiscal responsibility for these servies?

4. Has the number of state hospital students who are receiving instruction or related services from the local school increased or decreased in recent years?

Get details--Number of students, type of student, estimated cost per student--including teacher salary, transportation, and cost of additional facilities that may need to be built. Also information on type of service provided.

5. What changes would you like to see in the state or local agreement with the state hospitals?

6. What percentage of your budget comes from federal_____

state _____

local _____

CCS

	1979-80	1980-81
Number of referrals from school		
Number of referrals from other places		
Number of students served from school district		

	Number	Dollars	Who Pays How Much			Number of students served
			District	Agency	Other Source	
CCS STAFF/SERVICES						
Full-time OT/PT Therapists						
Part-time OT/PT Therapists						
Full-time OT/PT Aides						
Part-time OT/PT Aides						
Full-time Counselors						
Part-time Counselors						
Parent Trainees						
CCS Liaison person to Schools (School liaison person to CCS)						
EQUIPMENT						
Medical Therapy Unit (MTU)						
MTU Equipment						
MTU Equipment repair						
MTU Custodial service						
MTU Space						
Equipment other than MTU						
Used exclusively by one student						
Used by more than one student						
TRANSPORTATION						
Students to and from MTU						
Itinerant Therapists (travel reimbursement-- not salary)						
OTHER COSTS SHARED BY SCHOOLS OR OTHER AGENCIES						

MENTAL HEALTH

	1979-80	1980-81
Number of Referrals from Schools		
Number of Students or youth referrals from othe places		
Number of students served from school district		

	Number	Dollars	Who Pays How Much			Number and Type of Student Served
			District	Agency	Other Source	
STAFF/SERVICES						
Full-time Counselors						
Part-time Counselor						
Psycotherapy						
Training/In-service to school						
(Day treatment program)						
(Group counseling in schools)						
(Parent/family training/ counseling)						
EQUIPMENT						
Used exclusively by one student						
Used by more than one student						
TRANSPORTATION						
For students						
For Mental Health Staff						
OTHER COSTS SHARED BY SCHOOLS OR OTHER AGENCIES						

REGIONAL CENTERS

	1979-80	1980-81
Number of referrals from schools		
Number of referrals from other places		
Number of students served from school district		

	Number	Dollars	Who Pays How Much			Number of students served
			District	Agency	Other Source	
REGIONAL CENTER STAFF/SERVICES						
Full-time OT/PT						
Part-time OT/PT						
Full-time OT/PT Aides						
Part-time OT/PT Aides						
Full-time Counselors						
Part-time Counselors						
Speech Therapists						
Respite Care Staff						
Summer Camp Staff						
Parent Trainers						
Regional Center liaison person to schools						
(School liaison staff to center)						
EQUIPMENT						
Equipment that is used exclusively by one student						
Equpment that is used by more than one student						
TRANSPORTATION						
For students						
For Regional Center Staff						
NON-PUBLIC SCHOOL PLACEMENT						
Covered by Regional Center						
OTHER COSTS SHARED BY SCHOOLS OR Other Agencies						

REHAB

	1979-80	1980-81
Number of Special Education Referrals from schools		
Number of student or you referrals from other places		
Number of special education students served from school district		

	Number	Dollars	Who Pays How Much			Number and Type of Spec. Edu Stud. Serv
			District	Agency	Other Source	
REHAB STAFF/SERVICES						
Full-time OT/PT						
Part-time OT/PT						
Full-time OT/PT Aides						
Part-time OT/PT Aides						
Full-time Counselors						
Part-time Counselors						
Speech Therapists						
Occupational Skills Instructors						
Job Development/Placement Staff						
Family Support Services Staff						
Rehab Liaison Person to Schools (School Liaison person to Rehab)						
EQUIPMENT						
Aides/devices (individually owned)						
Aides/devices (used by more than one student)						
Tools (individually owned)						
Tools (used by more than one student)						
TRANSPORTATION						
For Students						
For Renab Staff						
OTHER COSTS SHARED BY SCHOOLS OR OTHER AGENCIES						

STATE HOSPITAL

	1979-80	1980-81
Number of State Hospital students receiving instruction		
Number of State Hospital students receiving related services in local schools		
Total number of State Hospital students receiving any type of service in local schools		

For all state hospital students receiving any type of service in local schools:
Breakdown by type of student:
Breakdown by type of setting (special school, special day class, etc.)

	Number	Dollars	Who Pays How Much			Number of students served
			District	Hospital	Other Source	
STAFF						
For instructional services that local schools provide for state hospital students:						
Full-time Teachers						
Part-time Teachers						
Full-time Aides						
Part-time Aides						
For each related service that the local school provides for state hospital students:						
Full-time Staff						
Part-time Staff						
Full-time Aides						
Part-time Aides						
State Hospital liaison to schools						
(School Liaison person to State Hospital)						
EQUIPMENT						
Costs for State hospital students used by more than one student						
TRANSPORTATION						
OTHER COSTS SHARED BY SCHOOLS OR OTHER AGENCIES						